All-State Medicaid and CHIP Call
October 10, 2023

This communication was printed, published, or produced and disseminated at U.S. taxpayer expense. The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance that it is based upon. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Agenda

- State Health Official Letter: Continuous Eligibility under the Consolidated Appropriations Act, 2023
- Mental Health and Substance Use Disorder Parity Request for Comments
- Open Mic Q and A

Continuous Eligibility under the Consolidated Appropriations Act, 2023

Stacey Green & Kristin Pacek

October 2023

Overview of the CAA, 2023 Continuous Eligibility Requirements for Children (1/2)

- Released SHO #23-004 on 9/29/23
  - The letter can be found here: letter to state health officials

Overview of the CAA, 2023 Continuous Eligibility Requirements for Children (2/2)

- Section 5112 of the CAA, 2023 amends sections 1902(e)(12) and 2107(e)(1) of the Social Security Act (the Act) to make it mandatory for states to provide 12 months of continuous eligibility (CE) for children under age 19 in Medicaid and CHIP (with limited exceptions)

- Effective Date: January 1, 2024

- SPA submission in Medicaid and CHIP is required for all states that will be newly adopting CE, and for some states that already have CE if the state currently imposes CE restrictions that will no longer be permissible on January 1, 2024

Pre-CAA State Plan Option (1/2)

- CE for children has been a long standing state plan option in Medicaid and CHIP

Medicaid Authorities:	CHIP Authorities:
*Section 1902(e)(12) and 42 CFR § 435.926**	*Section 2107(e)(1) and 42 CFR § 457.342**

* These regulations will continue to apply to mandatory CE after January 1, 2024, except where inconsistent with section 5112 of the CAA, 2023

- As of September 2023, 22 states have implemented CE in both Medicaid and CHIP. An additional nine states have implemented CE in at least one program

Pre-CAA State Plan Option (2/2)

- Children determined eligible at application or during an annual renewal remain eligible for a 12-month period ***regardless*** of most changes in circumstances, such as:
  - Changes in income or household composition,
  - Loss of Supplementation Security Income (SSI) for children eligible for Medicaid, or
  - Obtaining other health insurance for children enrolled in CHIP
- There are limited exceptions when a change in circumstance can result in termination of eligibility during a CE period under *§* 435.926 and *§* 457.342, such as when a child turns age 19, or ceases to be a resident of the state

Findings from the Literature

- Research has shown that children who are disenrolled for all or part of the year are more likely to have fair or poor health care status compared to children who have health insurance continuously throughout the year[1]

- CE has been shown to:
  - Reduce financial barriers to care for low-income families,
  - Promote improved health outcomes, and
  - Provide states with better tools to hold health plans accountable for quality care and improved health outcomes[2]

References:
1. Brantley, E., & Ku, L. (2022). Continuous eligibility for Medicaid associated with improved child health outcomes. *Medical Care Research and Review*, *79*(3), 404-413.

2. Park, E., Alker, J., & Corcoran, A. (2020). Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm. Retrieved from: https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm

CAA, 2023 – Mandatory CE (1/2)

- The CAA, 2023 amends sections 1902 (e)(12) and 2107(e)(1) of the Act to require one year of CE under the State plan or a waiver of the State plan for children under age 19 enrolled in Medicaid and CHIP

- The CAA, 2023 provides that children shall remain eligible for benefits until the earlier of —
  - The end of the 12-month period beginning on the date of an eligibility determination;
  - The time the individual attains the age of 19; or
  - The date that the individual ceases to be a resident of the state
  - Section 2107(e)(1)(K) also specifies that a child in CHIP who becomes eligible for Medicaid and transfers to that program must remain in Medicaid for the duration of 12-month period

CAA, 2023 – Mandatory CE (2/2)

- Although the regulatory exceptions currently at *§* 435.926 and *§* 457.342 are not explicitly referenced in the CAA, they will continue to apply:
  - The child or child's representative requests a voluntary termination of eligibility;
  - The agency determines that eligibility was erroneously granted; or
  - A child is deceased.
- CMS is still assessing how non-payment of premiums intersects with CE under the CAA. We intend to issue separate guidance on this topic in the near future.

CAA, 2023 – Start Date of CE Period

- *At Application*: The CE period for new applicants begins on the effective date of eligibility
  - Medicaid: Date of application or the first day of the month the application was submitted, depending on state option
  - CHIP: Date of application or another reasonable methodology, depending on state option

- *At Renewal:* A new CE period begins for individuals whose eligibility is renewed at a periodic renewal
  - The effective date of the child's renewal in accordance with § 435.916 for Medicaid (applied at § 457.343 to CHIP)

CAA, 2023 – CE Effective Date

- Mandatory CE under the CAA, 2023 is effective January 1, 2024
- *Applicants:* Individuals under age 19 applying for coverage on or after January 1, 2024 who are determined eligible for Medicaid or CHIP are entitled to 12 months CE unless an exception applies
- *Current Enrollees:* Individuals under age 19 who are enrolled in Medicaid or CHIP as of January 1, 2024 are entitled to 12 months of CE based on their last full determination of eligibility (generally at initial application or last period renewal), unless an exception applies

State Plan Amendments

- SPA submission in Medicaid and CHIP is required for a state if it is:
  - **Newly adopting** CE in one or both programs
  - Currently provides CE but **imposes restrictions** that will no longer be permissible under the CAA, 2023, such as:
    - Applying CE to only a subset of children, such as the from-conception-to-end of pregnancy population or children under a specific age
    - Permitting a CE period shorter than 12 months
- In order to meet the January 1, 2024 effective date, states will need to submit a SPA:
  - *Medicaid:* No later than March 31, 2024
  - *CHIP:* No later than the end of the state fiscal year in which January 1, 2024 falls.
- CMS will provide updated SPA templates for Medicaid and CHIP

Key Take Away Items

- Current CE regulations will continue to apply to CE after January 1, 2024, unless inconsistent with the CAA, 2023
- States continue to have the option to adopt CE prior to implementation of mandatory CE in 2024
- SPA submission in Medicaid and CHIP is required for all states that will be newly adopting CE, and for some states that already have CE
    - Please reach out to your Medicaid state lead or CHIP Project Officer with questions on SPA submissions
- CMS will also release FAQs on the CAA, 2023 CE requirement, including an FAQ on the non-payment of premium exception.

Resources

Medicaid.gov: Continuous Eligibility for Medicaid and CHIP
https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html

CCF Continuous Eligibility Program Design and Snapshot (July 2021) https://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf

Consolidated Appropriations Act, 2023 (CAA, 2023) Section 5112 https://www.congress.gov/bill/117th-congress/house-bill/2617/text

CENTERS FOR MEDICARE & MEDICAID SERVICES

Mental Health and Substance Use Disorder Parity Request for Comments

Kirsten Beronio

October 2023

How Mental Health and Substance Use Disorder Parity Law Applies to Medicaid and CHIP

- Ensuring compliance with federal parity requirements in Medicaid and CHIP is fundamental to improving access to care for enrollees who need mental health (MH) and/or substance use disorder (SUD) treatment.
- Most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) apply to coverage provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and the Children's Health Insurance Program (CHIP).
- Parity requirements apply to Medicaid MCOs through section 1932(b)(8) of the Social Security Act (the Act).
- Parity requirements apply to CHIP under section 2103(c)(7) of the Act.
- The Affordable Care Act included parity requirements for Medicaid ABPs in section 1937(b)(6) of the Act.
- Parity requirements do not apply to MH or SUD benefits for beneficiaries who receive only Medicaid non-ABP fee-for-service state plan services.

Overview of MH and SUD Parity Requirements

- Financial requirements (e.g., coinsurance and copays) and treatment limitations (e.g., limits on the number of outpatient visits, inpatient days covered, or other similar limits on scope or duration of treatment) imposed on MH or SUD benefits may not be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical or surgical benefits in a classification of benefits.
- Benefit classifications used for assessing parity compliance include inpatient, outpatient, emergency care, and prescription drugs.
- Treatment limitations include both quantitative and non-quantitative treatment limitations (NQTLs).
- Common NQTLs include, but are not limited to, prior authorization requirements, concurrent review requirements, medical management standards, formulary design for prescription drugs, and standards for provider admission to participate in a network.
- NQTLs may not be imposed on MH or SUD benefits in any benefit classification unless, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical or surgical benefits in the same classification.

Current Processes for Ensuring Compliance with Parity in Medicaid and CHIP

- CMS issued regulations in 2016 specifically focused on implementing the federal parity requirements that apply to Medicaid MCOs, CHIP, and Medicaid ABPs.
- States must provide documentation of compliance when benefits for MCO enrollees are split between the MCO and another managed care plan (e.g., a Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan) or when some benefits are provided through the MCO and some through FFS.
- States are required to update documentation when benefit or operational changes occur that may affect compliance with parity requirements.
- With regard to CHIP, states are required to submit state plan amendments (SPAs) and documentation to demonstrate compliance with parity requirements.
- States are responsible for ensuring Medicaid ABPs are in compliance with parity requirements through the SPA process.
- Request for Comment posted on Medicaid.gov on September 29, 2023: https://www.medicaid.gov/sites/default/files/2023-09/cmcs-mental-health-parity-092023.pdf

Questions for Comment (1/3)

1. What are some model formats (e.g., templates) and key questions to consider for improving efficiency and effectiveness of review of documentation of compliance with parity requirements in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?

2. What processes are states and managed care plans using to determine whether existing coverage policies are comparable for MH or SUD compared to medical or surgical benefits?

3. What are some key issues to focus on in reviewing policy or coverage documents that may indicate potential parity compliance issues including regarding NQTLs in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?

4. Which NQTLs and/or benefit classifications should be prioritized for review?

5. What should be the criteria for identifying high priority NQTLs for review?

Questions for Comment (2/3)

6. What are some measures or datapoints or other information that could help identify potential parity violations in Medicaid managed care arrangements, Medicaid ABPs, and CHIP?
   - Comparison of rates of coverage being denied for MH and SUD benefits compared to rates of coverage being denied for medical and surgical benefits,
   - Comparison of average and median appointment wait times for MH and SUD providers compared to medical and surgical providers,
   - Comparison of payment rates for MH and SUD providers compared to payment rates for medical/surgical providers,
   - Comparison of prevalence rates of MH conditions or SUDs among certain groups of enrollees compared to the percent of enrollees from those groups who are receiving treatment for MH conditions or SUDs,
   - Comparison of the average time from receipt of a claim to payment of that claim for MH and SUD benefits compared to medical and surgical benefits, and
   - Comparison of the percentage of MH and SUD network providers actively submitting claims compared to the percentage of medical and surgical providers actively submitting claims.

Questions for Comment (3/3)

- Are there any other measures that should be considered regarding provider network composition and standards for provider network admission including measures focused on –
  - Methods for determining reimbursement rates,
  - Credentialing standards, and
  - Procedures for ensuring a network includes an adequate number of each category of providers?
- What terminology should CMS define to facilitate collection and evaluation of data regarding these or other recommended measures?

7. How should data on these or other recommended measures be collected?

Additional Questions for Comment and Logistics

8. What are some potential follow-up protocols and corrective actions when measures indicate a potential parity violation in Medicaid managed care arrangements, ABPs, and CHIP?

9. What additional processes should be considered for assessing compliance with Medicaid and CHIP parity requirements, e.g., random audits?

10. Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?

11. Are there any particular MH conditions or SUDs or types of treatment that are at risk of not being covered in compliance with parity requirements for Medicaid managed care arrangements, Medicaid ABPs, or CHIP?

Comments must be submitted to the following email address **by December 4th, 2023**, to receive full consideration: MedicaidandCHIP-Parity@cms.hhs.gov.

Questions